

STATE OF MICHIGAN
DEPARTMENT OF ENERGY LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 106048-001

v

**American Community Mutual
Insurance Company
Respondent**

**Issued and entered
this 12th day of August 2009
by Ken Ross
Commissioner**

ORDER

**I
PROCEDURAL BACKGROUND**

On July 7, 2009, XXXXX, on behalf of his son XXXXX ("Petitioner") filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified American Community Mutual Insurance Company (ACM) of the external review and requested the information used in making its adverse determination. The Commissioner received the information and accepted the case for review on July 15, 2009.

This matter can be decided by an analysis of the terms of the Petitioner's health care coverage which are found in ACM's certificate of coverage, for Group #XXXXX issued to the XXXXX. (This document is referred to below as "the certificate" or "the policy.") The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

Petitioner has health care benefits through coverage under his family's group PPO coverage with ACM. Petitioner is XX years old and has a history of ADHD as well as behavioral and conduct disturbances. On December 3, 2008, he got into a loud argument with his parents. He locked himself in his room and began throwing objects. He was restrained by his father and the police were summoned. He was taken to the emergency room of the local hospital and later that night was admitted to the XXXXX. He was treated there for four days and was discharged December 8. The bill for the XXXXX care was \$6,561.16. ACM has declined to provide coverage for this care.

The Petitioner's parents appealed the denial through ACM's internal grievance process. ACM maintained its denial and issued a final adverse determination letter dated June 1, 2009.

III ISSUE

Did ACM properly deny coverage for Petitioner's care at the XXXXX?

IV ANALYSIS

Petitioner's Argument

The Petitioner's father says that his son's hospitalization should be covered because at the time he was suicidal and suffering from depression. He says that they were acting on medical advice when they took their son to the XXXXX facility where he was admitted for his own safety.

Respondent's Argument

In its final adverse determination letter dated June 1, 2009, Respondent provided the following explanation of its claim denial:

This policy covers medical expenses due to a sickness or injury. This expense is not due to a sickness or injury. The records received indicate that [Petitioner's] primary diagnosis for this admission was conduct disorder. Therefore, no benefits are eligible for this expense.

Respondent ACM does not cite any specific provisions in its certificate of coverage to support its argument.

Commissioner's Review

This matter must be resolved by applying several provisions of the certificate of coverage which describes Petitioner's health care benefits. The certificate does include a mental health benefit which provides:

Benefits will be paid if an insured individual incurs covered charges for Mental Health. The benefit will not exceed the amount shown on the schedule.

A Psychiatrist, who is responsible for the care of the insured individual, must be present on a regularly scheduled basis. . . .

Approved Psychiatric Facility means a Hospital, Community Mental Health Center, a Day Care Center or a Night Care Center engaged in the care and treatment of mental illness. In no event will an institution which is primarily engaged in providing custodial, recreational, social or educational services be considered an "Approved Psychiatric Facility."

Covered Charges are:

1. Care and Services of a
 - a. Psychiatrist;
 - b. Clinical Psychologist;
 - c. Psychiatric Social Worker;
 - d. Registered Nurse;
 - e. Licensed Clinical Social Worker;
2. Care, services or materials furnished by an Approved Psychiatric Facility.

The mental health benefit is 14 days per calendar year subject to deductibles and benefits percentages for both network and non-network services.

The certificate also includes a definition of "Mental and Nervous Disease or Disorder":

A clinically significant behavioral or psychological syndrome causing distress, disability or functional impairment, regardless of the cause.

Mental or nervous disorders include but are not limited to psychosis, depression, schizophrenia, bipolar affective disorder and other psychiatric illnesses listed in the current DSM Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Mental or nervous disorders do not include learning disabilities, attitudinal disorders or disciplinary problems.

ACM says that its policy does cover expenses due to a sickness or injury but Petitioner's expenses at XXXXX were not due to a sickness or injury. The policy does not define the terms

“sickness” or “injury.” However, the policy does explicitly state that it provides coverage for mental health care. Treatment at an inpatient hospital like XXXXX which is “engaged in the care and treatment of mental illness” does, by the policy’s own terms, constitute treatment at an Approved Psychiatric Facility. ACM’s final adverse determination asserts that, because Petitioner’s “primary diagnosis . . . was conduct disorder” no benefits are available. Presumably, this conclusion is based on the belief that conduct disorder is not a sickness or injury. However, conduct disorder is recognized in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (Diagnostic Code 312.82). As noted above, the policy states explicitly that coverage is provided for psychiatric illnesses listed in the DSM.

The Commissioner finds that Petitioner’s illness is covered by ACM’s policy.

**V
ORDER**

The final adverse determination of American Community Mutual Insurance Company is reversed. American Community Mutual shall provide the Commissioner proof of coverage no later than seven days from the date of payment. To enforce this Order, the Petitioner must report any complaint of noncompliance to the Office of Financial and Insurance Regulation, Health Plans Division, toll free at 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.